

115TH CONGRESS
1ST SESSION

S. _____

To bring stability to the individual insurance market, make insurance coverage more affordable, lower prescription drug prices, and improve Medicaid.

IN THE SENATE OF THE UNITED STATES

Mr. CARDIN introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To bring stability to the individual insurance market, make insurance coverage more affordable, lower prescription drug prices, and improve Medicaid.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “_____ Act of 2017”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MARKETPLACE STABILITY AND SECURITY

Sec. 101. Individual Market Reinsurance Fund.

Sec. 102. Public health insurance option.

TITLE II—HEALTH CARE FINANCIAL ASSISTANCE

- Sec. 201. Increase in eligibility for premium assistance tax credits.
 Sec. 202. Enhancements for reduced cost sharing.

TITLE III—DRUG PRICING

- Sec. 301. Requiring drug manufacturers to provide drug rebates for drugs dispensed to low-income individuals.
 Sec. 302. Negotiation of prices for medicare prescription drugs.
 Sec. 303. Guaranteed prescription drug benefits.
 Sec. 304. Full reimbursement for qualified retiree prescription drug plans.

TITLE IV—MEDICAID COLLABORATIVE CARE MODELS

- Sec. 401. Enhanced FMAP for medical assistance provided through a collaborative care model.

1 **TITLE I—MARKETPLACE**
 2 **STABILITY AND SECURITY**

3 **SEC. 101. INDIVIDUAL MARKET REINSURANCE FUND.**

4 (a) ESTABLISHMENT OF FUND.—

5 (1) IN GENERAL.—There is established the “In-
 6 dividual Market Reinsurance Fund” to be adminis-
 7 tered by the Secretary to provide funding for an in-
 8 dividual market stabilization reinsurance program in
 9 each State that complies with the requirements of
 10 this section.

11 (2) FUNDING.—There is appropriated to the
 12 Fund, out of any moneys in the Treasury not other-
 13 wise appropriated, such sums as are necessary to
 14 carry out this section (other than subsection (c)) for
 15 each calendar year beginning with 2018. Amounts
 16 appropriated to the Fund shall remain available
 17 without fiscal or calendar year limitation to carry
 18 out this section.

1 (b) INDIVIDUAL MARKET REINSURANCE PRO-
2 GRAM.—

3 (1) USE OF FUNDS.—The Secretary shall use
4 amounts in the Fund to establish a reinsurance pro-
5 gram under which the Secretary shall make reinsur-
6 ance payments to health insurance issuers with re-
7 spect to high-cost individuals enrolled in qualified
8 health plans offered by such issuers that are not
9 grandfathered health plans or transitional health
10 plans for any plan year beginning with the 2018
11 plan year. This subsection constitutes budget au-
12 thority in advance of appropriations Acts and rep-
13 resents the obligation of the Secretary to provide
14 payments from the Fund in accordance with this
15 subsection.

16 (2) AMOUNT OF PAYMENT.—The payment
17 made to a health insurance issuer under subsection
18 (a) with respect to each high-cost individual enrolled
19 in a qualified health plan issued by the issuer that
20 is not a grandfathered health plan or a transitional
21 health plan shall equal 80 percent of the lesser of—

22 (A) the amount (if any) by which the indi-
23 vidual's claims incurred during the plan year
24 exceeds—

1 (i) in the case of the 2018, 2019, or
2 2020 plan year, \$50,000; and

3 (ii) in the case of any other plan year,
4 \$100,000; or

5 (B) for plan years described in—

6 (i) subparagraph (A)(i), \$450,000;

7 and

8 (ii) subparagraph (A)(ii), \$400,000.

9 (3) INDEXING.—In the case of plan years be-
10 ginning after 2018, the dollar amounts that appear
11 in subparagraphs (A) and (B) of paragraph (2) shall
12 each be increased by an amount equal to—

13 (A) such amount; multiplied by

14 (B) the premium adjustment percentage
15 specified under section 1302(c)(4) of the Af-
16 fordable Care Act, but determined by sub-
17 stituting “2018” for “2013”.

18 (4) PAYMENT METHODS.—

19 (A) IN GENERAL.—Payments under this
20 subsection shall be based on such a method as
21 the Secretary determines. The Secretary may
22 establish a payment method by which interim
23 payments of amounts under this subsection are
24 made during a plan year based on the Sec-

1 retary's best estimate of amounts that will be
2 payable after obtaining all of the information.

3 (B) REQUIREMENT FOR PROVISION OF IN-
4 FORMATION.—

5 (i) REQUIREMENT.—Payments under
6 this subsection to a health insurance issuer
7 are conditioned upon the furnishing to the
8 Secretary, in a form and manner specified
9 by the Secretary, of such information as
10 may be required to carry out this sub-
11 section.

12 (ii) RESTRICTION ON USE OF INFOR-
13 MATION.—Information disclosed or ob-
14 tained pursuant to clause (i) is subject to
15 the HIPAA privacy and security law, as
16 defined in section 3009(a) of the Public
17 Health Service Act (42 U.S.C. 300jj-
18 19(a)).

19 (5) SECRETARY FLEXIBILITY FOR BUDGET
20 NEUTRAL REVISIONS TO REINSURANCE PAYMENT
21 SPECIFICATIONS.—If the Secretary determines ap-
22 propriate, the Secretary may substitute higher dollar
23 amounts for the dollar amounts specified under sub-
24 paragraphs (A) and (B) of paragraph (2) (and ad-
25 justed under paragraph (3), if applicable) if the Sec-

1 retary certifies that such substitutions, considered
2 together, neither increase nor decrease the total pro-
3 jected payments under this subsection.

4 (c) OUTREACH AND ENROLLMENT.—

5 (1) IN GENERAL.—During the period that be-
6 gins on January 1, 2018, and ends on December 31,
7 2020, the Secretary shall award grants to eligible
8 entities for the following purposes:

9 (A) OUTREACH AND ENROLLMENT.—To
10 carry out outreach, public education activities,
11 and enrollment activities to raise awareness of
12 the availability of, and encourage enrollment in,
13 qualified health plans.

14 (B) ASSISTING INDIVIDUALS TRANSITION
15 TO QUALIFIED HEALTH PLANS.—To provide as-
16 sistance to individuals who are enrolled in
17 health insurance coverage that is not a qualified
18 health plan enroll in a qualified health plan.

19 (C) ASSISTING ENROLLMENT IN PUBLIC
20 HEALTH PROGRAMS.—To facilitate the enroll-
21 ment of eligible individuals in the Medicare pro-
22 gram or in a State Medicaid program, as appro-
23 priate.

24 (D) RAISING AWARENESS OF PREMIUM AS-
25 SISTANCE AND COST-SHARING REDUCTIONS.—

1 To distribute fair and impartial information
2 concerning enrollment in qualified health plans
3 and the availability of premium assistance tax
4 credits under section 36B of the Internal Rev-
5 enue Code of 1986 and cost-sharing reductions
6 under section 1402 of the Patient Protection
7 and Affordable Care Act, and to assist eligible
8 individuals in applying for such tax credits and
9 cost-sharing reductions.

10 (2) ELIGIBLE ENTITIES DEFINED.—

11 (A) IN GENERAL.—In this subsection, the
12 term “eligible entity” means—

13 (i) a State; or

14 (ii) a nonprofit community-based or-
15 ganization.

16 (B) ENROLLMENT AGENTS.—Such term
17 includes a licensed independent insurance agent
18 or broker that has an arrangement with a State
19 or nonprofit community-based organization to
20 enroll eligible individuals in qualified health
21 plans.

22 (C) EXCLUSIONS.—Such term does not in-
23 clude an entity that—

24 (i) is a health insurance issuer; or

1 (ii) receives any consideration, either
2 directly or indirectly, from any health in-
3 surance issuer in connection with the en-
4 rollment of any qualified individuals or em-
5 ployees of a qualified employer in a quali-
6 fied health plan.

7 (3) PRIORITY.—In awarding grants under this
8 subsection, the Secretary shall give priority to
9 awarding grants to States or eligible entities in
10 States that have geographic rating areas at risk of
11 having no qualified health plans in the individual
12 market.

13 (4) FUNDING.—Out of any moneys in the
14 Treasury not otherwise appropriated, \$500,000,000
15 is appropriated to the Secretary for each of calendar
16 years 2018 through 2020, to carry out this sub-
17 section.

18 (d) REPORTS TO CONGRESS.—

19 (1) ANNUAL REPORT.—The Secretary shall
20 submit a report to Congress, not later than January
21 21, 2019, and each year thereafter, that contains
22 the following information for the most recently
23 ended year:

24 (A) The number and types of plans in each
25 State's individual market, specifying the num-

1 ber that are qualified health plans, grand-
2 fathered health plans, or health insurance cov-
3 erage that is not a qualified health plan.

4 (B) The impact of the reinsurance pay-
5 ments provided under this section on the avail-
6 ability of coverage, cost of coverage, and cov-
7 erage options in each State.

8 (C) The amount of premiums paid by indi-
9 viduals in each State by age, family size, geo-
10 graphic area in the State's individual market,
11 and category of health plan (as described in
12 subparagraph (A)).

13 (D) The process used to award funds for
14 outreach and enrollment activities awarded to
15 eligible entities under subsection (c), the
16 amount of such funds awarded, and the activi-
17 ties carried out with such funds.

18 (E) Such other information as the Sec-
19 retary deems relevant.

20 (2) EVALUATION REPORT.—Not later than Jan-
21 uary 31, 2022, the Secretary shall submit to Con-
22 gress a report that—

23 (A) analyzes the impact of the funds pro-
24 vided under this section on premiums and en-

1 rollment in the individual market in all States;
2 and

3 (B) contains a State-by-State comparison
4 of the design of the programs carried out by
5 States with funds provided under this section.

6 (e) DEFINITIONS.—In this section:

7 (1) SECRETARY.—The term “Secretary” means
8 the Secretary of the Department of Health and
9 Human Services.

10 (2) FUND.—The term “Fund” means the Indi-
11 vidual Market Reinsurance Fund established under
12 subsection (a).

13 (3) GRANDFATHERED HEALTH PLAN.—The
14 term “grandfathered health plan” has the meaning
15 given that term in section 1251(e) of the Patient
16 Protection and Affordable Care Act.

17 (4) HIGH-COST INDIVIDUAL.—The term “high-
18 cost individual” means an individual enrolled in a
19 qualified health plan (other than a grandfathered
20 health plan or a transitional health plan) who incurs
21 claims in excess of \$50,000 during a plan year.

22 (5) STATE.—The term “State” means each of
23 the 50 States and the District of Columbia.

24 (6) TRANSITIONAL HEALTH PLAN.—The term
25 “transitional health plan” means a plan continued

1 under the letter issued by the Centers for Medicare
2 & Medicaid Services on November 14, 2013, to the
3 State Insurance Commissioners outlining a transi-
4 tional policy for coverage in the individual and small
5 group markets to which section 1251 of the Patient
6 Protection and Affordable Care Act does not apply,
7 and under the extension of the transitional policy for
8 such coverage set forth in the Insurance Standards
9 Bulletin Series guidance issued by the Centers for
10 Medicare & Medicaid Services on March 5, 2014,
11 February 29, 2016, and February 13, 2017.

12 **SEC. 102. PUBLIC HEALTH INSURANCE OPTION.**

13 (a) IN GENERAL.—Part 3 of subtitle D of title I of
14 the Patient Protection and Affordable Care Act (Public
15 Law 111–148) is amended by adding at the end the fol-
16 lowing new section:

17 **“SEC. 1325. PUBLIC HEALTH INSURANCE OPTION.**

18 “(a) ESTABLISHMENT AND ADMINISTRATION OF A
19 PUBLIC HEALTH INSURANCE OPTION.—

20 “(1) ESTABLISHMENT.—For years beginning
21 with 2018, the Secretary of Health and Human
22 Services (in this subtitle referred to as the ‘Sec-
23 retary’) shall provide for the offering through Ex-
24 changes established under this title of a health bene-
25 fits plan (in this Act referred to as the ‘public health

1 insurance option’) that ensures choice, competition,
2 and stability of affordable, high-quality coverage
3 throughout the United States in accordance with
4 this section. In designing the option, the Secretary’s
5 primary responsibility is to create a low-cost plan
6 without compromising quality or access to care.

7 “(2) OFFERING THROUGH EXCHANGES.—

8 “(A) EXCLUSIVE TO EXCHANGES.—The
9 public health insurance option shall only be
10 made available through Exchanges established
11 under this title.

12 “(B) ENSURING A LEVEL PLAYING
13 FIELD.—Consistent with this section, the public
14 health insurance option shall comply with re-
15 quirements that are applicable under this title
16 to health benefits plans offered through such
17 Exchanges, including requirements related to
18 benefits, benefit levels, provider networks, no-
19 tices, consumer protections, and cost sharing.

20 “(C) PROVISION OF BENEFIT LEVELS.—

21 The public health insurance option—

22 “(i) shall offer bronze, silver, and gold
23 plans; and

24 “(ii) may offer platinum plans.

1 “(3) ADMINISTRATIVE CONTRACTING.—The
2 Secretary may enter into contracts for the purpose
3 of performing administrative functions (including
4 functions described in subsection (a)(4) of section
5 1874A of the Social Security Act) with respect to
6 the public health insurance option in the same man-
7 ner as the Secretary may enter into contracts under
8 subsection (a)(1) of such section. The Secretary has
9 the same authority with respect to the public health
10 insurance option as the Secretary has under sub-
11 sections (a)(1) and (b) of section 1874A of the So-
12 cial Security Act with respect to title XVIII of such
13 Act. Contracts under this subsection shall not in-
14 volve the transfer of insurance risk to such entity.

15 “(4) OMBUDSMAN.—The Secretary shall estab-
16 lish an office of the ombudsman for the public
17 health insurance option which shall have duties with
18 respect to the public health insurance option similar
19 to the duties of the Medicare Beneficiary Ombuds-
20 man under section 1808(c)(2) of the Social Security
21 Act. In addition, such office shall work with States
22 to ensure that information and notice is provided
23 that the public health insurance option is one of the
24 health plans available through an Exchange.

1 “(5) DATA COLLECTION.—The Secretary shall
2 collect such data as may be required to establish
3 premiums and payment rates for the public health
4 insurance option and for other purposes under this
5 section, including to improve quality and to reduce
6 racial, ethnic, and other disparities in health and
7 health care.

8 “(6) ACCESS TO FEDERAL COURTS.—The provi-
9 sions of Medicare (and related provisions of title II
10 of the Social Security Act) relating to access of
11 Medicare beneficiaries to Federal courts for the en-
12 forcement of rights under Medicare, including with
13 respect to amounts in controversy, shall apply to the
14 public health insurance option and individuals en-
15 rolled under such option under this title in the same
16 manner as such provisions apply to Medicare and
17 Medicare beneficiaries.

18 “(b) PREMIUMS AND FINANCING.—

19 “(1) ESTABLISHMENT OF PREMIUMS.—

20 “(A) IN GENERAL.—The Secretary shall
21 establish geographically adjusted premium rates
22 for the public health insurance option—

23 “(i) in a manner that complies with
24 the premium rules under paragraph (3);
25 and

1 “(ii) at a level sufficient to fully fi-
2 nance the costs of—

3 “(I) health benefits provided by
4 the public health insurance option;
5 and

6 “(II) administrative costs related
7 to operating the public health insur-
8 ance option.

9 “(B) CONTINGENCY MARGIN.—In estab-
10 lishing premium rates under subparagraph (A),
11 the Secretary shall include an appropriate
12 amount for a contingency margin.

13 “(2) ACCOUNT.—

14 “(A) ESTABLISHMENT.—There is estab-
15 lished in the Treasury of the United States an
16 account for the receipts and disbursements at-
17 tributable to the operation of the public health
18 insurance option, including the start-up funding
19 under subparagraph (B). Section 1854(g) of
20 the Social Security Act shall apply to receipts
21 described in the previous sentence in the same
22 manner as such section applies to payments or
23 premiums described in such section.

24 “(B) START-UP FUNDING.—

1 “(i) IN GENERAL.—In order to pro-
2 vide for the establishment of the public
3 health insurance option there is hereby ap-
4 propriated to the Secretary, out of any
5 funds in the Treasury not otherwise appro-
6 priated, \$2,000,000,000. In order to pro-
7 vide for initial claims reserves before the
8 collection of premiums, there is hereby ap-
9 propriated to the Secretary, out of any
10 funds in the Treasury not otherwise appro-
11 priated, such sums as necessary to cover
12 90 days worth of claims reserves based on
13 projected enrollment.

14 “(ii) AMORTIZATION OF START-UP
15 FUNDING.—The Secretary shall provide for
16 the repayment of the startup funding pro-
17 vided under clause (i) to the Treasury in
18 an amortized manner over the 10-year pe-
19 riod beginning with 2018.

20 “(iii) LIMITATION ON FUNDING.—
21 Nothing in this subsection shall be con-
22 strued as authorizing any additional appro-
23 priations to the account, other than such
24 amounts as are otherwise provided with re-

1 spect to other health benefits plans partici-
2 pating under the Exchange involved.

3 “(3) INSURANCE RATING RULES.—The pre-
4 mium rate charged for the public health insurance
5 option may not vary except as provided under sec-
6 tion 2701 of the Public Health Service Act.

7 “(c) PAYMENT RATES FOR ITEMS AND SERVICES.—

8 “(1) RATES ESTABLISHED BY SECRETARY.—

9 “(A) IN GENERAL.—The Secretary shall
10 establish payment rates for the public health in-
11 surance option for services and health care pro-
12 viders consistent with this subsection and may
13 change such payment rates in accordance with
14 subsection (d).

15 “(B) INITIAL PAYMENT RULES.—

16 “(i) IN GENERAL.—During 2018,
17 2019, and 2020, the Secretary shall set
18 the payment rates under this subsection
19 for services and providers described in sub-
20 paragraph (A) equal to the payment rates
21 for equivalent services and providers under
22 parts A and B of Medicare, subject to
23 clause (ii), paragraph (4), and subsection
24 (d).

1 “(ii) EXCEPTIONS.—The Secretary
2 may determine the extent to which Medi-
3 care adjustments applicable to base pay-
4 ment rates under parts A and B of Medi-
5 care for graduate medical education and
6 disproportionate share hospitals shall apply
7 under this section.

8 “(C) FOR NEW SERVICES.—The Secretary
9 shall modify payment rates described in sub-
10 paragraph (B) in order to accommodate pay-
11 ments for services, such as well-child visits, that
12 are not otherwise covered under Medicare.

13 “(D) PRESCRIPTION DRUGS.—Payment
14 rates under this subsection for prescription
15 drugs that are not paid for under part A or
16 part B of Medicare shall be at rates negotiated
17 by the Secretary.

18 “(2) SUBSEQUENT PERIODS; PROVIDER NET-
19 WORK.—

20 “(A) SUBSEQUENT PERIODS.—Beginning
21 with 2021 and for subsequent years, the Sec-
22 retary shall continue to use an administrative
23 process to set such rates in order to promote
24 payment accuracy, to ensure adequate bene-
25 ficiary access to providers, and to promote af-

1 fordability and the efficient delivery of medical
2 care consistent with subsection (a)(1). Such
3 rates shall not be set at levels expected to in-
4 crease average medical costs per enrollee cov-
5 ered under the public health insurance option
6 beyond what would be expected if the process
7 under paragraph (1)(B) were continued, as cer-
8 tified by the Office of the Actuary of the Cen-
9 ters for Medicare & Medicaid Services.

10 “(B) ESTABLISHMENT OF A PROVIDER
11 NETWORK.—Health care providers participating
12 under Medicare are participating providers in
13 the public health insurance option unless they
14 opt out in a process established by the Sec-
15 retary.

16 “(3) ADMINISTRATIVE PROCESS FOR SETTING
17 RATES.—Chapter 5 of title 5, United States Code
18 shall apply to the process for the initial establish-
19 ment of payment rates under this subsection but not
20 to the specific methodology for establishing such
21 rates or the calculation of such rates.

22 “(4) CONSTRUCTION.—Nothing in this section
23 shall be construed as limiting the Secretary’s author-
24 ity to correct for payments that are excessive or defi-
25 cient, taking into account the provisions of sub-

1 section (a)(1) and any appropriate adjustments
2 based on the demographic characteristics of enrollees
3 covered under the public health insurance option,
4 but in no case shall the correction of payments
5 under this paragraph result in a level of expendi-
6 tures per enrollee that exceeds the level of expendi-
7 tures that would have occurred under paragraph
8 (1)(B), as certified by the Office of the Actuary of
9 the Centers for Medicare & Medicaid Services.

10 “(5) CONSTRUCTION.—Nothing in this section
11 shall be construed as affecting the authority of the
12 Secretary to establish payment rates, including pay-
13 ments to provide for the more efficient delivery of
14 services, such as the initiatives provided for under
15 subsection (d).

16 “(6) LIMITATIONS ON REVIEW.—There shall be
17 no administrative or judicial review of a payment
18 rate or methodology established under this sub-
19 section or under subsection (d).

20 “(d) MODERNIZED PAYMENT INITIATIVES AND DE-
21 LIVERY SYSTEM REFORM.—

22 “(1) IN GENERAL.—For plan years beginning
23 with 2018, the Secretary may utilize innovative pay-
24 ment mechanisms and policies to determine pay-
25 ments for items and services under the public health

1 insurance option. The payment mechanisms and
2 policies under this subsection may include patient-
3 centered medical home and other care management
4 payments, accountable care organizations, value-
5 based purchasing, bundling of services, differential
6 payment rates, performance or utilization based pay-
7 ments, partial capitation, and direct contracting with
8 providers. Payment rates under such payment mech-
9 anisms and policies shall not be set at levels ex-
10 pected to increase average medical costs per enrollee
11 covered under the public health insurance option be-
12 yond what would be expected if the process under
13 subsection (c)(1)(B) were continued, as certified by
14 the Office of the Actuary of the Centers for Medi-
15 care & Medicaid Services.

16 “(2) REQUIREMENTS FOR INNOVATIVE PAY-
17 MENTS.—The Secretary shall design and implement
18 the payment mechanisms and policies under this
19 subsection in a manner that—

20 “(A) seeks to—

21 “(i) improve health outcomes;

22 “(ii) reduce health disparities (includ-
23 ing racial, ethnic, and other disparities);

24 “(iii) provide efficient and affordable
25 care;

1 “(iv) address geographic variation in
2 the provision of health services; or

3 “(v) prevent or manage chronic ill-
4 ness; and

5 “(B) promotes care that is integrated, pa-
6 tient-centered, high-quality, and efficient.

7 “(3) ENCOURAGING THE USE OF HIGH VALUE
8 SERVICES.—To the extent allowed by the benefit
9 standards applied to all health benefits plans partici-
10 pating under the Exchange involved, the public
11 health insurance option may modify cost sharing and
12 payment rates to encourage the use of services that
13 promote health and value.

14 “(4) NON-UNIFORMITY PERMITTED.—Nothing
15 in this subtitle shall prevent the Secretary from
16 varying payments based on different payment struc-
17 ture models (such as accountable care organizations
18 and medical homes) under the public health insur-
19 ance option for different geographic areas.

20 “(e) PROVIDER PARTICIPATION.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish conditions of participation for health care pro-
23 viders under the public health insurance option.

24 “(2) LICENSURE OR CERTIFICATION.—The Sec-
25 retary shall not allow a health care provider to par-

1 participate in the public health insurance option unless
2 such provider is appropriately licensed or certified
3 under State law.

4 “(3) PAYMENT TERMS FOR PROVIDERS.—

5 “(A) PHYSICIANS.—The Secretary shall
6 provide for the annual participation of physi-
7 cians under the public health insurance option,
8 for which payment may be made for services
9 furnished during the year, in one of 2 classes:

10 “(i) PREFERRED PHYSICIANS.—Those
11 physicians who agree to accept the pay-
12 ment rate established under this section
13 (without regard to cost-sharing) as the
14 payment in full.

15 “(ii) PARTICIPATING, NON-PRE-
16 FERRED PHYSICIANS.—Those physicians
17 who agree not to impose charges (in rela-
18 tion to the payment rate described in sub-
19 section (c) for such physicians) that exceed
20 the ratio permitted under section
21 1848(g)(2)(C) of the Social Security Act.

22 “(B) OTHER PROVIDERS.—The Secretary
23 shall provide for the participation (on an annual
24 or other basis specified by the Secretary) of
25 health care providers (other than physicians)

1 under the public health insurance option under
2 which payment shall only be available if the
3 provider agrees to accept the payment rate es-
4 tablished under subsection (c) (without regard
5 to cost-sharing) as the payment in full.

6 “(4) EXCLUSION OF CERTAIN PROVIDERS.—
7 The Secretary shall exclude from participation under
8 the public health insurance option a health care pro-
9 vider that is excluded from participation in a Fed-
10 eral health care program (as defined in section
11 1128B(f) of the Social Security Act).

12 “(f) APPLICATION OF FRAUD AND ABUSE PROVI-
13 SIONS.—Provisions of law (other than criminal law provi-
14 sions) identified by the Secretary by regulation, in con-
15 sultation with the Inspector General of the Department
16 of Health and Human Services, that impose sanctions
17 with respect to waste, fraud, and abuse under Medicare,
18 such as the False Claims Act (31 U.S.C. 3729 et seq.),
19 shall also apply to the public health insurance option.

20 “(g) MEDICARE DEFINED.—For purposes of this sec-
21 tion, the term ‘Medicare’ means the health insurance pro-
22 grams under title XVIII of the Social Security Act.”.

23 (b) CONFORMING AMENDMENTS.—

1 (1) TREATMENT AS QUALIFIED HEALTH
2 PLAN.—Section 1301(a)(2) of the Patient Protection
3 and Affordable Care Act is amended—

4 (A) in the heading, by inserting “, THE
5 PUBLIC HEALTH INSURANCE OPTION,” before
6 “AND”; and

7 (B) by inserting “the public health insur-
8 ance option under section 1325,” before “and a
9 multi-State plan”.

10 (2) LEVEL PLAYING FIELD.—Section 1324(a)
11 of such Act is amended by inserting “the public
12 health insurance option under section 1325,” before
13 “or a multi-State qualified health plan”.

14 **TITLE II—HEALTH CARE**
15 **FINANCIAL ASSISTANCE**

16 **SEC. 201. INCREASE IN ELIGIBILITY FOR PREMIUM ASSIST-**
17 **ANCE TAX CREDITS.**

18 (a) IN GENERAL.—Subparagraph (A) of section
19 36B(c)(1) of the Internal Revenue Code of 1986 is amend-
20 ed by striking “400 percent” and inserting “600 percent”.

21 (b) CONFORMING AMENDMENT.—The table con-
22 tained in clause (i) of section 36B(b)(3)(A)(i) of the Inter-
23 nal Revenue Code of 1986 is amended by striking “400%”
24 and inserting “600%”.

1 (c) RECONCILIATION OF CREDIT AND ADVANCE
2 CREDIT.—Clause (i) of section 36B(f)(2)(B) of the Inter-
3 nal Revenue Code of 1986 is amended—

4 (1) by striking “In the case of” and all that fol-
5 lows through “the amount of” and inserting “The
6 amount of”, and

7 (2) by striking “but less than 400%” in the
8 table.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 December 31, 2017.

12 **SEC. 202. ENHANCEMENTS FOR REDUCED COST SHARING.**

13 (a) MODIFICATION OF AMOUNT.—

14 (1) IN GENERAL.—Section 1402(c)(2) of the
15 Patient Protection and Affordable Care Act is
16 amended to read as follows:

17 “(2) ADDITIONAL REDUCTION.—The Secretary
18 shall establish procedures under which the issuer of
19 a qualified health plan to which this section applies
20 shall further reduce cost-sharing under the plan in
21 a manner sufficient to—

22 “(A) in the case of an eligible insured
23 whose household income is not less than 100
24 percent but not more than 200 percent of the
25 poverty line for a family of the size involved, in-

1 crease the plan’s share of the total allowed
2 costs of benefits provided under the plan to 95
3 percent of such costs;

4 “(B) in the case of an eligible insured
5 whose household income is more than 200 per-
6 cent but not more than 300 percent of the pov-
7 erty line for a family of the size involved, in-
8 crease the plan’s share of the total allowed
9 costs of benefits provided under the plan to 90
10 percent of such costs; and

11 “(C) in the case of an eligible insured
12 whose household income is more than 300 per-
13 cent but not more than 400 percent of the pov-
14 erty line for a family of the size involved, in-
15 crease the plan’s share of the total allowed
16 costs of benefits provided under the plan to 85
17 percent of such costs.”.

18 (2) CONFORMING AMENDMENT.—Clause (i) of
19 section 1402(e)(1)(B) of such Act is amended to
20 read as follows:

21 “(i) IN GENERAL.—The Secretary
22 shall ensure the reduction under this para-
23 graph shall not result in an increase in the
24 plan’s share of the total allowed costs of
25 benefits provided under the plan above—

1 “(I) 95 percent in the case of an
2 eligible insured described in para-
3 graph (2)(A);

4 “(II) 90 percent in the case of an
5 eligible insured described in para-
6 graph (2)(B); and

7 “(III) 85 percent in the case of
8 an eligible insured described in para-
9 graph (2)(C).”.

10 (3) EFFECTIVE DATE.—The amendments made
11 by this subsection shall apply to plan years begin-
12 ning after December 31, 2017.

13 (b) FUNDING.—Section 1402 of the Patient Protec-
14 tion and Affordable Care Act is amended by adding at
15 the end the following new subsection:

16 “(g) FUNDING.—Out of any funds in the Treasury
17 not otherwise appropriated, there are appropriated to the
18 Secretary such sums as may be necessary for payments
19 under this section.”.

20 **TITLE III—DRUG PRICING**

21 **SEC. 301. REQUIRING DRUG MANUFACTURERS TO PROVIDE** 22 **DRUG REBATES FOR DRUGS DISPENSED TO** 23 **LOW-INCOME INDIVIDUALS.**

24 (a) IN GENERAL.—Section 1860D–2 of the Social
25 Security Act (42 U.S.C. 1395w–102) is amended—

1 (1) in subsection (e)(1), in the matter preceding
2 subparagraph (A), by inserting “and subsection (f)”
3 after “this subsection”; and

4 (2) by adding at the end the following new sub-
5 section:

6 “(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR
7 REBATE ELIGIBLE INDIVIDUALS.—

8 “(1) REQUIREMENT.—

9 “(A) IN GENERAL.—For plan years begin-
10 ning on or after January 1, 2019, in this part,
11 the term ‘covered part D drug’ does not include
12 any drug or biological product that is manufac-
13 tured by a manufacturer that has not entered
14 into and have in effect a rebate agreement de-
15 scribed in paragraph (2).

16 “(B) 2018 PLAN YEAR REQUIREMENT.—
17 Any drug or biological product manufactured by
18 a manufacturer that declines to enter into a re-
19 bate agreement described in paragraph (2) for
20 the period beginning on January 1, 2018, and
21 ending on December 31, 2018, shall not be in-
22 cluded as a ‘covered part D drug’ for the subse-
23 quent plan year.

24 “(2) REBATE AGREEMENT.—A rebate agree-
25 ment under this subsection shall require the manu-

1 manufacturer to provide to the Secretary a rebate for
2 each rebate period (as defined in paragraph (6)(B))
3 ending after December 31, 2017, in the amount
4 specified in paragraph (3) for any covered part D
5 drug of the manufacturer dispensed after December
6 31, 2017, to any rebate eligible individual (as de-
7 fined in paragraph (6)(A)) for which payment was
8 made by a PDP sponsor or MA organization under
9 this part for such period, including payments passed
10 through the low-income and reinsurance subsidies
11 under sections 1860D–14 and 1860D–15(b), respec-
12 tively. Such rebate shall be paid by the manufac-
13 turer to the Secretary not later than 30 days after
14 the date of receipt of the information described in
15 section 1860D–12(b)(7), including as such section is
16 applied under section 1857(f)(3), or 30 days after
17 the receipt of information under subparagraph (D)
18 of paragraph (3), as determined by the Secretary.
19 Insofar as not inconsistent with this subsection, the
20 Secretary shall establish terms and conditions of
21 such agreement relating to compliance, penalties,
22 and program evaluations, investigations, and audits
23 that are similar to the terms and conditions for re-
24 bate agreements under paragraphs (3) and (4) of
25 section 1927(b).

1 “(3) REBATE FOR REBATE ELIGIBLE MEDICARE
2 DRUG PLAN ENROLLEES.—

3 “(A) IN GENERAL.—The amount of the re-
4 bate specified under this paragraph for a manu-
5 facturer for a rebate period, with respect to
6 each dosage form and strength of any covered
7 part D drug provided by such manufacturer
8 and dispensed to a rebate eligible individual,
9 shall be equal to the product of—

10 “(i) the total number of units of such
11 dosage form and strength of the drug so
12 provided and dispensed for which payment
13 was made by a PDP sponsor or an MA or-
14 ganization under this part for the rebate
15 period, including payments passed through
16 the low-income and reinsurance subsidies
17 under sections 1860D–14 and 1860D–
18 15(b), respectively; and

19 “(ii) the amount (if any) by which—

20 “(I) the Medicaid rebate amount
21 (as defined in subparagraph (B)) for
22 such form, strength, and period, ex-
23 ceeds

24 “(II) the average Medicare drug
25 program rebate eligible rebate amount

1 (as defined in subparagraph (C)) for
2 such form, strength, and period.

3 “(B) MEDICAID REBATE AMOUNT.—For
4 purposes of this paragraph, the term ‘Medicaid
5 rebate amount’ means, with respect to each
6 dosage form and strength of a covered part D
7 drug provided by the manufacturer for a rebate
8 period—

9 “(i) in the case of a single source
10 drug or an innovator multiple source drug,
11 the amount specified in paragraph
12 (1)(A)(ii)(II) or (2)(C) of section 1927(c)
13 plus the amount, if any, specified in sub-
14 paragraph (A)(ii) of paragraph (2) of such
15 section, for such form, strength, and pe-
16 riod; or

17 “(ii) in the case of any other covered
18 outpatient drug, the amount specified in
19 paragraph (3)(A)(i) of such section for
20 such form, strength, and period.

21 “(C) AVERAGE MEDICARE DRUG PROGRAM
22 REBATE ELIGIBLE REBATE AMOUNT.—For pur-
23 poses of this subsection, the term ‘average
24 Medicare drug program rebate eligible rebate
25 amount’ means, with respect to each dosage

1 form and strength of a covered part D drug
2 provided by a manufacturer for a rebate period,
3 the sum, for all PDP sponsors under part D
4 and MA organizations administering an MA-
5 PD plan under part C, of—

6 “(i) the product, for each such spon-
7 sor or organization, of—

8 “(I) the sum of all rebates, dis-
9 counts, or other price concessions (not
10 taking into account any rebate pro-
11 vided under paragraph (2) or any dis-
12 counts under the program under sec-
13 tion 1860D-14A) for such dosage
14 form and strength of the drug dis-
15 pensed, calculated on a per-unit basis,
16 but only to the extent that any such
17 rebate, discount, or other price con-
18 cession applies equally to drugs dis-
19 pensed to rebate eligible Medicare
20 drug plan enrollees and drugs dis-
21 pensed to PDP and MA-PD enrollees
22 who are not rebate eligible individuals;
23 and

24 “(II) the number of the units of
25 such dosage and strength of the drug

1 dispensed during the rebate period to
2 rebate eligible individuals enrolled in
3 the prescription drug plans adminis-
4 tered by the PDP sponsor or the MA-
5 PD plans administered by the MA or-
6 ganization; divided by

7 “(ii) the total number of units of such
8 dosage and strength of the drug dispensed
9 during the rebate period to rebate eligible
10 individuals enrolled in all prescription drug
11 plans administered by PDP sponsors and
12 all MA-PD plans administered by MA or-
13 ganizations.

14 “(D) USE OF ESTIMATES.—The Secretary
15 may establish a methodology for estimating the
16 average Medicare drug program rebate eligible
17 rebate amounts for each rebate period based on
18 bid and utilization information under this part
19 and may use these estimates as the basis for
20 determining the rebates under this section. If
21 the Secretary elects to estimate the average
22 Medicare drug program rebate eligible rebate
23 amounts, the Secretary shall establish a rec-
24 onciliation process for adjusting manufacturer
25 rebate payments not later than 3 months after

1 the date that manufacturers receive the infor-
2 mation collected under section 1860D-
3 12(b)(7)(B).

4 “(4) LENGTH OF AGREEMENT.—The provisions
5 of paragraph (4) of section 1927(b) (other than
6 clauses (iv) and (v) of subparagraph (B)) shall apply
7 to rebate agreements under this subsection in the
8 same manner as such paragraph applies to a rebate
9 agreement under such section.

10 “(5) OTHER TERMS AND CONDITIONS.—The
11 Secretary shall establish other terms and conditions
12 of the rebate agreement under this subsection, in-
13 cluding terms and conditions related to compliance,
14 that are consistent with this subsection.

15 “(6) DEFINITIONS.—In this subsection and sec-
16 tion 1860D–12(b)(7):

17 “(A) REBATE ELIGIBLE INDIVIDUAL.—The
18 term ‘rebate eligible individual’ means—

19 “(i) a subsidy eligible individual (as
20 defined in section 1860D–14(a)(3)(A));

21 “(ii) a Medicaid beneficiary treated as
22 a subsidy eligible individual under clause
23 (v) of section 1860D–14(a)(3)(B); and

24 “(iii) any part D eligible individual
25 not described in clause (i) or (ii) who is de-

1 terminated for purposes of the State plan
2 under title XIX to be eligible for medical
3 assistance under clause (i), (iii), or (iv) of
4 section 1902(a)(10)(E).

5 “(B) REBATE PERIOD.—The term ‘rebate
6 period’ has the meaning given such term in sec-
7 tion 1927(k)(8).”.

8 (b) REPORTING REQUIREMENT FOR THE DETER-
9 MINATION AND PAYMENT OF REBATES BY MANUFACTUR-
10 ERS RELATED TO REBATE FOR REBATE ELIGIBLE MEDI-
11 CARE DRUG PLAN ENROLLEES.—

12 (1) REQUIREMENTS FOR PDP SPONSORS.—Sec-
13 tion 1860D–12(b) of the Social Security Act (42
14 U.S.C. 1395w–112(b)) is amended by adding at the
15 end the following new paragraph:

16 “(7) REPORTING REQUIREMENT FOR THE DE-
17 TERMINATION AND PAYMENT OF REBATES BY MANU-
18 FACTURERS RELATED TO REBATE FOR REBATE ELI-
19 GIBLE MEDICARE DRUG PLAN ENROLLEES.—

20 “(A) IN GENERAL.—For purposes of the
21 rebate under section 1860D–2(f) for contract
22 years beginning on or after January 1, 2019,
23 each contract entered into with a PDP sponsor
24 under this part with respect to a prescription

1 drug plan shall require that the sponsor comply
2 with subparagraphs (B) and (C).

3 “(B) REPORT FORM AND CONTENTS.—Not
4 later than a date specified by the Secretary, a
5 PDP sponsor of a prescription drug plan under
6 this part shall report to each manufacturer—

7 “(i) information (by National Drug
8 Code number) on the total number of units
9 of each dosage, form, and strength of each
10 drug of such manufacturer dispensed to re-
11 bate eligible Medicare drug plan enrollees
12 under any prescription drug plan operated
13 by the PDP sponsor during the rebate pe-
14 riod;

15 “(ii) information on the price dis-
16 counts, price concessions, and rebates for
17 such drugs for such form, strength, and
18 period;

19 “(iii) information on the extent to
20 which such price discounts, price conces-
21 sions, and rebates apply equally to rebate
22 eligible Medicare drug plan enrollees and
23 PDP enrollees who are not rebate eligible
24 Medicare drug plan enrollees; and

1 “(iv) any additional information that
2 the Secretary determines is necessary to
3 enable the Secretary to calculate the aver-
4 age Medicare drug program rebate eligible
5 rebate amount (as defined in paragraph
6 (3)(C) of such section), and to determine
7 the amount of the rebate required under
8 this section, for such form, strength, and
9 period.

10 Such report shall be in a form consistent with
11 a standard reporting format established by the
12 Secretary.

13 “(C) SUBMISSION TO SECRETARY.—Each
14 PDP sponsor shall promptly transmit a copy of
15 the information reported under subparagraph
16 (B) to the Secretary for the purpose of audit
17 oversight and evaluation.

18 “(D) CONFIDENTIALITY OF INFORMA-
19 TION.—The provisions of subparagraph (D) of
20 section 1927(b)(3), relating to confidentiality of
21 information, shall apply to information reported
22 by PDP sponsors under this paragraph in the
23 same manner that such provisions apply to in-
24 formation disclosed by manufacturers or whole-
25 salers under such section, except—

1 “(i) that any reference to ‘this sec-
2 tion’ in clause (i) of such subparagraph
3 shall be treated as being a reference to this
4 section;

5 “(ii) the reference to the Director of
6 the Congressional Budget Office in clause
7 (iii) of such subparagraph shall be treated
8 as including a reference to the Medicare
9 Payment Advisory Commission; and

10 “(iii) clause (iv) of such subparagraph
11 shall not apply.

12 “(E) OVERSIGHT.—Information reported
13 under this paragraph may be used by the In-
14 specter General of the Department of Health
15 and Human Services for the statutorily author-
16 ized purposes of audit, investigation, and eval-
17 uations.

18 “(F) PENALTIES FOR FAILURE TO PRO-
19 VIDE TIMELY INFORMATION AND PROVISION OF
20 FALSE INFORMATION.—In the case of a PDP
21 sponsor—

22 “(i) that fails to provide information
23 required under subparagraph (B) on a
24 timely basis, the sponsor is subject to a
25 civil money penalty in the amount of

1 \$10,000 for each day in which such infor-
2 mation has not been provided; or

3 “(ii) that knowingly (as defined in
4 section 1128A(i)) provides false informa-
5 tion under such subparagraph, the sponsor
6 is subject to a civil money penalty in an
7 amount not to exceed \$100,000 for each
8 item of false information.

9 Such civil money penalties are in addition to
10 other penalties as may be prescribed by law.
11 The provisions of section 1128A (other than
12 subsections (a) and (b)) shall apply to a civil
13 money penalty under this subparagraph in the
14 same manner as such provisions apply to a pen-
15 alty or proceeding under section 1128A(a).”.

16 (2) APPLICATION TO MA ORGANIZATIONS.—Sec-
17 tion 1857(f)(3) of the Social Security Act (42
18 U.S.C. 1395w-27(f)(3)) is amended by adding at
19 the end the following:

20 “(D) REPORTING REQUIREMENT RELATED
21 TO REBATE FOR REBATE ELIGIBLE MEDICARE
22 DRUG PLAN ENROLLEES.—Section 1860D-
23 12(b)(7).”.

24 (c) DEPOSIT OF REBATES INTO MEDICARE PRE-
25 SCRIPTION DRUG ACCOUNT.—Section 1860D-16(c) of the

1 Social Security Act (42 U.S.C. 1395w–116(c)) is amended
2 by adding at the end the following new paragraph:

3 “(6) REBATE FOR REBATE ELIGIBLE MEDICARE
4 DRUG PLAN ENROLLEES.—Amounts paid under a re-
5 bate agreement under section 1860D–2(f) shall be
6 deposited into the Account.”.

7 (d) EXCLUSION FROM DETERMINATION OF BEST
8 PRICE AND AVERAGE MANUFACTURER PRICE UNDER
9 MEDICAID.—

10 (1) EXCLUSION FROM BEST PRICE DETERMINA-
11 TION.—Section 1927(c)(1)(C)(ii)(I) of the Social Se-
12 curity Act (42 U.S.C. 1396r–8(c)(1)(C)(ii)(I)) is
13 amended by inserting “and amounts paid under a
14 rebate agreement under section 1860D–2(f)” after
15 “this section”.

16 (2) EXCLUSION FROM AVERAGE MANUFAC-
17 TURE PRICE DETERMINATION.—Section
18 1927(k)(1)(B)(i) of the Social Security Act (42
19 U.S.C. 1396r–8(k)(1)(B)(i)) is amended—

20 (A) in subclause (IV), by striking “and”
21 after the semicolon;

22 (B) in subclause (V), by striking the period
23 at the end and inserting “; and”; and

24 (C) by adding at the end the following:

1 “(VI) amounts paid under a re-
2 bate agreement under section 1860D-
3 2(f).”.

4 **SEC. 302. NEGOTIATION OF PRICES FOR MEDICARE PRE-**
5 **SCRIPTION DRUGS.**

6 Section 1860D-11 of the Social Security Act (42
7 U.S.C. 1395w-111) is amended by striking subsection (i)
8 (relating to noninterference) and inserting the following:

9 “(i) NEGOTIATION; NO NATIONAL FORMULARY OR
10 PRICE STRUCTURE.—

11 “(1) NEGOTIATION OF PRICES WITH MANUFAC-
12 TURERS.—In order to ensure that beneficiaries en-
13 rolled under prescription drug plans and MA-PD
14 plans pay the lowest possible price, the Secretary
15 shall have and exercise authority similar to that of
16 other Federal entities that purchase prescription
17 drugs in bulk to negotiate contracts with manufac-
18 turers of covered part D drugs, consistent with the
19 requirements and in furtherance of the goals of pro-
20 viding quality care and containing costs under this
21 part.

22 “(2) NO NATIONAL FORMULARY OR PRICE
23 STRUCTURE.—In order to promote competition
24 under this part and in carrying out this part, the
25 Secretary may not require a particular formulary or

1 institute a price structure for the reimbursement of
2 covered part D drugs.”.

3 **SEC. 303. GUARANTEED PRESCRIPTION DRUG BENEFITS.**

4 (a) IN GENERAL.—Section 1860D–3 of the Social
5 Security Act (42 U.S.C. 1395w–103) is amended to read
6 as follows:

7 “ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION
8 DRUG COVERAGE

9 “SEC. 1860D–3. (a) ASSURING ACCESS TO A CHOICE
10 OF COVERAGE.—

11 “(1) CHOICE OF AT LEAST THREE PLANS IN
12 EACH AREA.—Beginning on January 1, 2019, the
13 Secretary shall ensure that each part D eligible indi-
14 vidual has available, consistent with paragraph (2),
15 a choice of enrollment in—

16 “(A) a nationwide prescription drug plan
17 offered by the Secretary in accordance with
18 subsection (b); and

19 “(B) at least 2 qualifying plans (as defined
20 in paragraph (3)) in the area in which the indi-
21 vidual resides, at least one of which is a pre-
22 scription drug plan.

23 “(2) REQUIREMENT FOR DIFFERENT PLAN
24 SPONSORS.—The requirement in paragraph (1)(B) is
25 not satisfied with respect to an area if only one enti-
26 ty offers all the qualifying plans in the area.

1 “(3) QUALIFYING PLAN DEFINED.—For pur-
2 poses of this section, the term ‘qualifying plan’
3 means—

4 “(A) a prescription drug plan;

5 “(B) an MA–PD plan described in section
6 1851(a)(2)(A)(i) that provides—

7 “(i) basic prescription drug coverage;

8 or

9 “(ii) qualified prescription drug cov-
10 erage that provides supplemental prescrip-
11 tion drug coverage so long as there is no
12 MA monthly supplemental beneficiary pre-
13 mium applied under the plan, due to the
14 application of a credit against such pre-
15 mium of a rebate under section
16 1854(b)(1)(C); or

17 “(C) a nationwide prescription drug plan
18 offered by the Secretary in accordance with
19 subsection (b).

20 “(b) HHS AS PDP SPONSOR FOR A NATIONWIDE
21 PRESCRIPTION DRUG PLAN.—

22 “(1) IN GENERAL.—The Secretary, acting
23 through the Administrator of the Centers for Medi-
24 care & Medicaid Services, shall take such steps as
25 may be necessary to qualify and serve as a PDP

1 sponsor and to offer a prescription drug plan that
2 offers basic prescription drug coverage throughout
3 the United States. Such a plan shall be in addition
4 to, and not in lieu of, other prescription drug plans
5 offered under this part.

6 “(2) PREMIUM; SOLVENCY; AUTHORITIES.—In
7 carrying out paragraph (1), the Secretary—

8 “(A) shall establish a premium in the
9 amount of \$37 for months in 2019 and, for
10 months in subsequent years, in the amount
11 specified in this paragraph for months in the
12 previous year increased by the annual percent-
13 age increase described in section 1860D-
14 2(b)(6) (relating to growth in medicare pre-
15 scription drug costs per beneficiary) for the
16 year involved;

17 “(B) is deemed to have met any applicable
18 solvency and capital adequacy standards; and

19 “(C) shall exercise such authorities (includ-
20 ing the use of regional or other pharmaceutical
21 benefit managers) as the Secretary determines
22 necessary to offer the prescription drug plan in
23 the same or a comparable manner as is the case
24 for prescription drug plans offered by private
25 PDP sponsors.

1 “(c) FLEXIBILITY IN RISK ASSUMED.—In order to
2 ensure access pursuant to subsection (a) in an area the
3 Secretary may approve limited risk plans under section
4 1860D–11(f) for the area.”.

5 (b) CONFORMING AMENDMENT.—Section 1860D–
6 11(g) of the Social Security Act (42 U.S.C. 1395w–
7 111(g)) is amended by adding at the end the following
8 new paragraph:

9 “(8) APPLICATION.—This subsection shall not
10 apply on or after January 1, 2019.”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to plan years beginning on or after
13 January 1, 2019.

14 **SEC. 304. FULL REIMBURSEMENT FOR QUALIFIED RETIREE**
15 **PRESCRIPTION DRUG PLANS.**

16 (a) ELIMINATION OF TRUE OUT-OF-POCKET LIMITA-
17 TION.—Section 1860D–2(b)(4)(C)(iii) of the Social Secu-
18 rity Act (42 U.S.C. 1395w–102(b)(4)(C)(iii) is amend-
19 ed—

20 (1) in subclause (III), by striking “or” at the
21 end;

22 (2) in subclause (IV), by striking the period at
23 the end and inserting “; or”; and

24 (3) by adding at the end the following new sub-
25 clause:

1 “(V) under a qualified retiree
2 prescription drug plan (as defined in
3 section 1860D–22(a)(2)).”.

4 (b) EQUALIZATION OF SUBSIDIES.—Notwithstanding
5 any other provision of law, the Secretary of Health and
6 Human Services shall provide for such increase in the spe-
7 cial subsidy payment amounts under section 1860D–
8 22(a)(3) of the Social Security Act (42 U.S.C. 1395w–
9 132(a)(3)) as may be appropriate to provide for payments
10 in the aggregate equivalent to the payments that would
11 have been made under section 1860D–15 of such Act (42
12 U.S.C. 1395w–115) if the individuals were not enrolled
13 in a qualified retiree prescription drug plan. In making
14 such computation, the Secretary shall not take into ac-
15 count the application of the amendments made by section
16 1202 of the Medicare Prescription Drug, Improvement,
17 and Modernization Act of 2003 (Public Law 108–173; 117
18 Stat. 2480).

19 (c) EFFECTIVE DATE.—This section, and the amend-
20 ments made by this section, shall take effect on January
21 1, 2019.

1 **TITLE IV—MEDICAID**
2 **COLLABORATIVE CARE MODELS**
3 **SEC. 401. ENHANCED FMAP FOR MEDICAL ASSISTANCE**
4 **PROVIDED THROUGH A COLLABORATIVE**
5 **CARE MODEL.**

6 Section 1905 of the Social Security Act (42 U.S.C.
7 1396d) is amended—

8 (1) in the first sentence of subsection (b)—

9 (A) by striking “, and (5)” and inserting
10 “, (5)”; and

11 (B) by inserting “, and (6) beginning Jan-
12 uary 1, 2018, the Federal medical assistance
13 percentage shall be 100 percent with respect to
14 medical assistance provided by a State for items
15 and services delivered through a collaborative
16 care model (as defined in subsection (ee)) or an
17 evidence-based model (which may be a collabo-
18 rative care model) that integrates behavioral
19 health services into primary care treatment” be-
20 fore the period;

21 (2) by adding at the end the following new sub-
22 section:

23 “(ee) **COLLABORATIVE CARE MODELS.**—

24 “(1) **IN GENERAL.**—The term ‘collaborative
25 care model’ means a model for providing health care

1 to individuals which adheres to the core services de-
2 scribed in paragraph (2) and under which each indi-
3 vidual receiving care through the model receives care
4 from a collaborative team of providers described in
5 paragraph (3).

6 “(2) CORE SERVICES.—The services described
7 in this paragraph are:

8 “(A) Comprehensive care management.

9 “(B) Care coordination and health pro-
10 motion.

11 “(C) Comprehensive transitional care from
12 inpatient settings to other settings, including
13 appropriate follow up.

14 “(D) Individual and family support, which
15 shall include authorized representatives.

16 “(E) Referral to community and social
17 support services, as appropriate.

18 “(F) The use of health information tech-
19 nology to link services, as feasible and appro-
20 priate.

21 “(3) COLLABORATIVE HEALTH TEAM.—A team
22 described in this paragraph includes the following
23 providers:

1 “(A) A primary care provider such as a
2 primary care physician, an internist, a nurse
3 practitioner, or a physician’s assistant.

4 “(B) Care management staff which shall
5 include a member who is a registered profes-
6 sional nurse, a clinical social worker, or a psy-
7 chologist, and who specializes in primary care
8 management and is trained to provide evidence
9 based care coordination, brief behavioral inter-
10 ventions, and to support treatments (including
11 medications) initiated by a primary care physi-
12 cian.

13 “(C) A psychiatric consultant who shall
14 advise the primary care provider as necessary
15 (either in person or remotely).”.